Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DAVID M BLOOME 7401 S MAIN STREET HOUSTON TX 77030	MFDR Tracking #: M4-11-0069-01 (formerly M4-10-2115-01) DWC Claim #: Injured Employee:
Respondent Name and Box #: TRAVELERS INDEMNITY CO Box #: 05	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the final request for reconsideration: "Fondren Orthopedic Group does not have a contract with Focus/Aetna. These charges should have been paid at 100% of the State Fee Schedule allowable."

Amount in Dispute: $16.32

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated in a letter to Requestor dated 10/26/2010: "This is to confirm that David M. Bloome is not a participating provider in the Aetna Workers' Comp Access® (AWCA) network effective 8/25/2006. The AWCA Operations Team reviewed the bill for [injured worker] and confirms the bill should have been priced as non par and will be corrected if resubmitted."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/26/08	99212	(52.83/38.087) x $37.94 = $52.63 $52.43 (Requestors MFG Mar) - $46.31 = $6.12	$6.12	$6.12
11/26/08	99080	$15.00 - $13.20 = $1.80	$1.80	$1.80
11/26/08	L4350	$74.12 x 125% = $92.65 - $61.60 = $8.40	$8.40	$8.40
			Total Due:	$16.32

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated12/19/08:

   - FO3L – A2 – Contract adjustment. Any reduction is in accordance with Focus/AETNA Workers Comp Access LLC.

   Explanation of benefits dated 11/17/09:

   - Z036 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was

processed properly. Appeals will not be considered after the first day of the 11th month.

Issues

1. Did the requestor have a contractual agreement with Focus/Aetna?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the letter dated October 26, 2010, submitted by the Respondent on October 29, 2010 the AWCA Operations team reviewed the bill for the injured worker and confirmed the bill should have been priced as non par. The AWCA team also asked that the Requestor re-submit the bill and it would be corrected. A phone call to the health care providers contact person, Patti Gilbert, reveals that Ms. Gilbert no longer works for Fondren Orthopedics Group; a message was left for Mr. Garcia; however a return call was not received.
2. In accordance with 28 TAC Section §134.203 and 28 TAC Section §129.5 the Respondent did not reimburse the Requestor properly.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16.32.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $16.32reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $16.32 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	02/03/2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.